Claim For Continuing Compensation
On Account Of Disability

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

STATEMENT OF INJURED EMPLOYEE - SEE INSTRUCTIONS ON REVERSE SIDE

1. NAME OF INJURED EMPLOYEE *(Last, first, middle)*

2. OWCP FILE NUMBER, IF KNOWN

3. HOME MAILING ADDRESS *(Include ZIP code)*

4. SOCIAL SECURITY NUMBER

5. DATE AND HOUR OF INJURY
(Mo., day, year)
☐ AM
☐ PM

6. PERIOD COMPENSATION IS CLAIMED AS A RESULT OF PAY LOSS
(Mo., day, year) IF PAY LOSS WAS INTERMITTENT ATTACH SEPARATE SHEET SHOWING DATES AND HOURS OF PAY LOSS.
FROM: THROUGH:

7. HAVE YOU RECEIVED ANY LEAVE PAY DURING THE PERIOD SHOWN IN ITEM 6?
☐ YES ☐ NO SHOW INCLUSIVE DATES. FROM: THROUGH:
IF LEAVE USE WAS INTERMITTENT, ATTACH SEPARATE SHEET SHOWING DATES AND HOURS USED.

8. DO YOU WISH TO REPURCHASE LEAVE?
☐ YES ☐ NO

9. COMPLETE THIS ITEM IF YOU WORKED DURING THE PERIOD SHOWN IN ITEM 6. ATTACH A SEPARATE SHEET IF NEEDED.

a. SALARIED EMPLOYMENT.

DATES & HOURS WORKED	PAY RATE *(Per hour, day or week)*	TOTAL AMOUNT EARNED	TYPE WORK PERFORMED	NAMES & ADDRESS OF EMPLOYER

b. COMMISSION AND SELF-EMPLOYMENT. *SHOW ALL ACTIVITIES, WHETHER OR NOT INCOME RESULTED FROM YOUR EFFORTS.*

DATES & HOURS WORKED	NAME AND ADDRESS OF BUSINESS	SELF-EMPLOYED ☐ COMMISSION ☐	TYPE OF ACTIVITY PERFORMED	INCOME DERIVED (ATTACH EXPLANATION IF NEEDED)

10. IF YOU HAVE APPLIED FOR EMPLOYMENT WITH THE U.S. TRAINING AND EMPLOYMENT SERVICE GIVE THE FOLLOWING:

REGISTRATION NO. DATE OF REGISTRATION OFFICE ADDRESS

11. IF YOU WERE ONLY PARTIALLY DISABLED AND DID NOT WORK, STATE REASON FOR NOT WORKING.

12. IF, SINCE FILING YOUR INITIAL CLAIM FOR COMPENSATION, YOU HAVE APPLIED FOR OR RECEIVED VA BENEFITS BASED ON MILITARY SERVICE FOR THE UNITED STATES, GIVE THE FOLLOWING:

CLAIM NO. NATURE OF DISABILITY AND MONTHLY PAYMENT NAME AND ADDRESS OF OFFICE WHERE CLAIM IS FILED

13. IF, SINCE FILING YOUR INITIAL CLAIM FOR COMPENSATION, YOU HAVE APPLIED FOR OR RECEIVED AN ANNUITY UNDER THE CIVIL SERVICE RETIREMENT ACT OR OTHER FEDERAL RETIREMENT OR DISABILITY LAW, GIVE THE FOLLOWING:

CLAIM NO. AMOUNT OF MONTHLY PAYMENT NAME AND ADDRESS OF OFFICE WHERE CLAIM IS FILED

14. SIGNATURE OF EMPLOYEE OR PERSON ACTING ON EMPLOYEE'S BEHALF. Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

15. DATE *(Mo., day, year)*

For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402

Form CA-8
Revised Oct. 1986

Clear Form

STATEMENT OF OFFICIAL SUPERIOR

16. IF EMPLOYEE HAS RETURNED TO WORK, SHOW DATE AND HOUR *(Mo., day, year)*

☐ AM
☐ PM

17. SHOW EMPLOYEE'S WORK WEEK ON RETURN TO DUTY, IF OTHER THAN MONDAY THRU FRIDAY

S	M	T	W	T	F	S

18. HAS EMPLOYEE RECEIVED ANY PAY FOR WORK, LEAVE, SUBSISTENCE, QUARTERS OR OTHER REMUNERATION FROM YOUR AGENCY DURING THE PERIOD SHOWN IN ITEM 6 ON THE REVERSE SIDE?

☐ YES ☐ NO

19. IF ANSWER TO ITEM 18 IS YES, SHOW:

AMOUNT: $

TYPE OF PAYMENT:

PERIOD: FROM: _____ THROUGH: _____

20. IF THERE HAS BEEN ANY CHANGE IN EMPLOYEE'S HEALTH BENEFIT ENROLLMENT AND/OR OPTIONAL INSURANCE SINCE PREVIOUS CLAIM FOR COMPENSATION WAS SUBMITTED, PLEASE EXPLAIN. *(i.e. change of plan or option; if additional deductions have been made by the agency, show amount and period.)*

21. REMARKS

22. SIGNATURE OF OFFICIAL SUPERIOR	23. TITLE	24. DATE *(mo., day, year)*

INSTRUCTIONS FOR INJURED EMPLOYEE

a. Items 1 through 15 on the reverse side should be completed by the injured employee or by somone acting on the employee's behalf. The form should then be given to the official superior.

b. The injured employee should file Form CA-8 each two weeks during the period of disability unless otherwise notified by OWCP. Forms may be obtain from OWCP or the employing agency.

c. Employees are advised that fraudulent claims are punishable by a fine of not more than $2,000, or imprisonment for not more than one year, or both.

INSTRUCTIONS FOR OFFICIAL SUPERIOR

a. The official superior must complete items 16 through 24 and forward the form to the appropriate OWCP office.

b. The official superior must also complete items 1 through 6 on Form CA-20a before sending that form to the attending physician. It will also be necessary for the official superior to show in item 3 on the reverse of the Form CA-20a, the address of the OWCP office to which the physician should send the completed form.

If additional space is required for any reply, a separate sheet of paper may be used, numbering the answers to correspond with items on the form.

NOTE: FAILURE TO SUBMIT THIS FORM PROPERLY COMPLETED WITH SUPPORTING MEDICAL EVIDENCE WILL DELAY PAYMENT OF COMPENSATION.